APPLICATION FOR PROPOSED PRACTICE LOCATION

NCSEAA
North Carolina State Education Assistance Authority

Borrower received funding through:
☐ HSM ☐ BGDSL ☐ BGMSL ☐ OSL

Name: _____ Date: ___/___/___
(MM/DD/YYYY)

Borrower ID No.: _____

Home Address: _____ Home Phone: (___) _____

City: _____ State: _____ Zip Code: _____

PRACTICE TYPE			
☐ Dentist	☐ Primary Care Physician (select type or specialty below)		
☐ Optometrist	☐ General Medicine	☐ Pediatrician	☐ Family Medicine
☐ Podiatrist	☐ OB - GYN	☐ ER Physician	☐ Internal Medicine
☐ Pharmacist	☐ Psychiatrist	☐ Geriatrics	
☐ Physician's Assistant			
☐ Other, please specify:			

Name of Practice: _____

Address: _____ Phone: (___) _____

City: _____ State: _____ Zip Code: _____ County: _____

I request that my repayment obligation to the State of North Carolina be cancelled through service. I authorize my employer to provide information to the SEAA about the dates of my employment, the position I hold, and my employment status as needed to qualify for service cancellation of my loan(s). I understand that I must work full-time in order to qualify for service credit.

_____ _____
Signature of Borrower (full name) Date (MM/DD/YYYY)

TO BE COMPLETED BY HUMAN RESOURCES OR AUTHORIZED OFFICIAL

This practice will/does serve clients in the following categories: (check all that apply)			
☐ Medicare	☐ Medicaid	☐ Indigent	☐ Sliding Scale Fees Accepted

I certify that the above named has been/is employed ☐ full-time ☐ part-time as a (an)

_____ at our facility beginning on: ___/___/___
Position Title (MM/DD/YYYY)

If applicable, employment ended: ___/___/___
(MM/DD/YYYY)

The above named has worked continuously since the above stated date of employment began? ☐ No* ☐ Yes
*If no, please attach explanation and include dates of the absence.

I attest that the foregoing information is true and correct to the best of my knowledge.

_____ _____
Signature of Official Date (MM/DD/YYYY)

_____ _____
Name and Title (Please print or type) Telephone Number

Please direct questions to Repayment Services at (919) 549-8614 or 1(800) 700-1775, option # 2.

RETURN THIS FORM TO: SEAA, PO Box 14223, Research Triangle Park, NC 27709